Editorials

Three Possible Futures for Medicine

THESE ARE TIMES of enormous change. Change is occurring almost everywhere. Quite simply, modern science and technology are responsible for the changes that are producing a new and different social, economic, and political world right before our eyes. This can be seen in medicine as well as in society. And the changes that are occurring in both medicine and society are inter-related. When these inter-relationships and interactions are examined, three possible related futures for medicine may be discerned.

One future will surely be *bioscience and hi-tech medicine.* Progress has been spectacular. It has mesmerized both the profession and the public. It has momentum. What may yet be accomplished by bioscience and hi-tech medicine boggles the mind. The possibilities will capture the imagination of medical scientists for a long time to come. But in medicine as in society, progress in science and technology is producing social, economic, and political changes that must be addressed. There are unmistakable signs that society is becoming disillusioned with what is being accomplished in health care, while at the same time generously supporting further scientific and technologic progress in medicine. The conquest of disease and prolongation of life have turned out to produce more illness and disability rather than less and at ever greater and now unacceptable cost. Scientific medicine is not satisfying many patients or much of the public. Patients are expecting better outcomes, and the public is expecting better results for the health dollars spent. Patients are beginning to take their personal care into their own hands, and the public is beginning to move health care itself into the public arena. Physicians are beginning to be viewed more and more as specialized and subspecialized technicians with all the social, economic, and political implications that this entails for the future of the profession. If bioscience and technology are not the end all, then what else may be in the future of medicine? If it is true that patients are expecting better outcomes and the public is expecting better results for their health dollars, then here may be found possibilities for two other futures for medicine.

What affects patient care outcomes besides biologic science and biotechnology? What has been called the "art" of medicine comes to mind. The art deals with such things as human behaviors, attitudes, cultural beliefs, interactions between physician and patient, interactions among health professionals, and the orchestrating of human and health care resources in patient care. This human side of patient care has received less study and attention than it deserves. There is a body of knowledge to be learned, and there are human skills to be acquired by physicians if they are to achieve the best in patient care outcomes and have satisfied patients, families, and third party payers of care. The art of medicine belongs on a par with bioscience and biotechnology as a vital part of modern medicine. Maybe it is time for a more disciplined approach to the neglected art. Perhaps it is time to develop the all-important human side of patient care as a *social science of medical practice,* a new social science that would be rooted in the practice, and with a new focus on all of the human factors that affect patient care outcomes. This could be a second possible future for medicine and perhaps a most important one for the medical profession as modern patient care evolves in today's society.

Then the public is also expecting better health care results for the dollars spent. In a sense the public is in a role somewhat like a patient whose health status is not satisfactory and who needs a physician's help. Perhaps here is an opportunity, or even a need, for yet a third future for medicine, a new role of *medicine as physician to society.* Physicians are citizens with special training and special insights into what constitutes health and illness. They also have highly developed problem-solving skills, especially where the problems are complex and constantly changing. There is a potential for physicians collectively, through their medical societies and associations at various levels, to work with the larger society as they would with a patient, to help diagnose and then work collaboratively with society to treat a health ailment. The process is a familiar one: the chief complaint, history, examination, diagnostic studies, consultations as needed, a working diagnosis, agreement on a treatment plan, implementation of the treatment plan, monitoring of progress, making course corrections as necessary until the problem is solved or an acceptable steady state is reached. The process works in patient care, and, suitably adapted, it should work in societal health care.

It is not too soon to begin thinking about these possible futures of medicine. In the final analysis the role of medicine, and its scope and responsibility, will be determined by society and not by the profession. This has always been the case. But physicians can also influence events in patient care and health care. This also has always been the case. The profession has but to listen to the complaint and then respond with its science, its humanity, and its professional skills. These three possible futures open up new vistas for medicine, which may not be so new after all.

MSMW

Hypertension in the Elderly

HYPERTENSION IN THE ELDERLY is commanding an increasing amount of attention—not surprisingly, given the upward shift taking place in the age distribution of our society and the epidemiology of elevated arterial pressures. This attention is nicely focused on the many areas surrounding the prevalence, significance, and management of hypertension in the elderly by Whitcomb and Byyny elsewhere in this issue.[1] The phenomenon of simultaneously declining fertility and mortality has led to a demographic transition in which experts foresee a doubling of the population aged 65 or older in the next 30 years. No matter which cutoff point is chosen to define hypertension in older persons, nor the number of measurements used to establish the diagnosis, any pathophysiologic process affecting 40% to 65% of an estimated 50 million persons in our society is a problem of enormous consequence. Prospective epidemiologic studies have established high blood pressure, and in particular high systolic pressure, as the single greatest risk factor in the elderly, except for age itself. Not only is it the strongest predictor of cardiovascular disease, but elderly persons, especially those with hypertension, are less likely to survive a cardiovascular event.